Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	OF CORRECTION IDENTIFICATION NUMBER: NVS2808AGZ			A. BUILDING B. WING		03/1/	; 4/2011
NAME OF PR				I RESS, CITY, STA	ATE. ZIP CODE	03/14	4/2011
				SA VISTA AV			
SPECIAL	LOVING CARE ALZHEIN	IERS CENTER	LAS VEGA	S, NV 89118			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
Y 000	Initial Comments			Y 000			
	by the Health Division prohibiting any crimin actions or other claim available to any party state, or local laws. This Statement of De a result of an annual conducted in your fact 3/14/11. This State L conducted by the auth Powers of the Health The facility is licensed for Group beds which with Alzheimer's disease.	hority of NRS 449.150, Division. d for five Residential Far provide care to personase, Category II residente of the survey was for the reviewed and five reviewed. a grade of D.	I as is, ral, ed as / n acility as ints.				
Y 050 SS=F	449.194(1) Administrator's Responsibilities-Oversight			Y 050			
	1. Provide oversight members of the staff to ensure that resider and protective supervin compliance with the	a residential facility shat and direction for the of the facility as necess its receive needed servision and that the facilit e requirements of NAC inclusive, and chapter	sary vices ty is				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

AND DIAN OF CODDECTION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS2808AGZ		B. WING		03/1/	; 4/2011
NAME OF PR	OVIDER OR SUPPLIER	NVOZOGAGE	STREET ADDI	I RESS, CITY, STA	ATE, ZIP CODE	1 03/1-	7/2011
SPECIAL	LOVING CARE ALZHEIM	ERS CENTER		SA VISTA AV S, NV 89118	E		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Y 050	Continued From page	2 1		Y 050			
Y 070 SS=E	Based on interview, re observation from 2/8/administrator failed to direction to the staff to the needed services at they required. Evidenty 1070, Y103, Y105, Y10	11 through 3/14/11, the provide oversight and provide oversight and provide oversight and provide ensure residents received and protective supervisives by citations at TAGs 106, Y253, Y276, Y451 1878, Y895, Y930, Y936 19. 3 ations of Caregiver-8 has been as the providing esidents of a mot met as evidenced been on 3/14/11, the facility of caregivers received eiting (Employee #4 and #	eived ion s , s, ours	Y 070			

			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				A. BUILDING B. WING		С	
	NVS2808AGZ					03/1	4/2011
NAME OF PR	ROVIDER OR SUPPLIER			RESS, CITY, STA			
SPECIAL LOVING CARE ALZHEIMERS CENTER				SA VISTA AV S, NV 89118	E		
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
Y 103	Continued From page	e 2		Y 103			
Y 103 SS=F	3 449.200(1)(d) Personnel File - NAC 441A / Tuberculosis			Y 103			
	a separate personnel member of the staff of	se provided in subsection file must be kept for east of a facility and must inc trates required pursuant for the employee.	ach lude:				
Y 105 SS=F	This Regulation is not met as evidenced by: Based on record review on 3/14/11, the facility failed to ensure 3 of 5 employees complied with NAC 441A.375 regarding tuberculosis (TB) testing and pre-employment physicals for the protection of all residents (Employee #1-no pre-employment physical; Employee #2 and #3- no 2 step TB tests or pre-employment physicals). This was a repeat deficiency from the 2/16/10 annual State Licensure survey. Severity: 2 Scope: 3		Y 105				
SS=F	a separate personnel member of the staff of	se provided in subsection file must be kept for ea of a facility and must inc iance with NRS 449.17	ach lude:				

			X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				A. BUILDING B. WING		С	
		NVS2808AGZ			03/14/201		
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA			
SPECIAL	LOVING CARE ALZHEIN	IERS CENTER		SA VISTA AV S, NV 89118	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FL LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROFICIENCY)	ULD BE	(X5) COMPLETE DATE
Y 105	Continued From page	e 3		Y 105			
	Based on record revirfailed to ensure 4 of 5 background check re to 449.188 (Employer background results, Esigned criminal history	quirements of NRS 449 es #1 and #5- no FBI Employees #2 and #3-n y statement, no fingerp ate and FBI background	ity 0.176 o rints				
Y 253 SS=F	253 449.217(4) Adequate Supplies of Food			Y 253			
	ensure that there is a fresh food and at least	NAC 449.217 4. The administrator of a residential facility shall ensure that there is at least a 2-day supply of resh food and at least a 1-week supply of canned food in the facility at all times.					
	Based on observation the facility failed to ha fresh food and at least food in the facility for	ot met as evidenced by: n and interview on 2/8/1 ave at least a 2-day sup st a 1 week supply of ca all residents (Meals we other facility and delive	1, oply of anned ore				
	Severity: 2	Scope: 3					
Y 276 SS=F	449.2175(7) Nutrition	and Service of Food		Y 276			
	NAC 449.2175 7. Meals must be nut appropriate manner, and prepared with reg	suitable for the resident	ts				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SU COMPLET	
				A. BUILDING			
		NVS2808AGZ		B. WING			4/2011
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
SPECIAL	LOVING CARE ALZHEIN	IERS CENTER		SA VISTA AV S, NV 89118	E		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
Y 276	Continued From page	e 4		Y 276			
	three meals a day muintervals. The times a served must be poster may elapse between breakfast the next day available between means a day muintervals.	ious requirements. At I ust be served at regula at which meals will be ed. Not more than 14 he the meal in the evening y. Snacks must be make als for the residents where their physicians from each	r ours g and de ho				
	This Regulation is not met as evidenced by: Based on observation and interview on 2/8/11, the facility failed to prepare meals in the facility (Meals were being prepared and cooked at another facility and then delivered to the home). Severity: 2 Scope: 3						
Y 451 SS=F	51 449.231(2)(a)-(f) First Aid Kit			Y 451			
	The first-aid kit must (a) A germicide safe to (b) Sterile gauze pade (c) Adhesive bandage adhesive tape; (d) Disposable gloves (e) A shield or mask to is administering cardiand (f) A thermometer or of the cardial safe to the control of the cardial safe to the cardi	s; es, rolls of gauze and	who on; d to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS2808AGZ		A. BUILDING B. WING	<u> </u>		C
NAME OF D				 RESS, CITY, STA	ATE ZIR CODE		14/2011
NAME OF PE				SA VISTA AV			
SPECIAL	LOVING CARE ALZHEIN	MERS CENTER		S, NV 89118	-		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
Y 451	Continued From page	e 5		Y 451			
	Based on observation the facility failed to haw with the required commot contain a shield conly caregiver on dut and had to call to get administrator on whee Severity: 2 Scope:	re to find it).	/11, ble kit did the the kit	Y 859			
SS=E	resident, the facility s general physical examinis physician. The re		of a ∶by				
	Based on record revi						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		NVS2808AGZ		B. WING			I 4/2011
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
SPECIAL	LOVING CARE ALZHEI	MERS CENTER		6562 W MESA VISTA AVE LAS VEGAS, NV 89118			
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
Y 876	Continued From page 6			Y 876			
Y 876 SS=B	449.2742(4) Medication Administration NRS			Y 876			
	administration of me resident needs the c caregiver may assist controlled substance	ise provided in this ver shall assist in the dication to a resident if the taregiver's assistance. A t the ultimate user of es or dangerous drugs of ribed in subsection 6 of	A nly if				
	This Regulation is not met as evidenced by: Based on record review on 3/14/11, the facility failed to ensure that an ultimate user agreement was obtained for 2 of 4 residents (Resident #1 and #3).		lity nent				
	This was a repeat de annual State Licensi	eficiency from the 2/16/1 ure survey.	0				
	Severity: 1 Scope	e: 2					
Y 877 SS=E	449.2742(5) OTC m Supplements	edications & Dietary		Y 877			
	supplement may be resident's physician administration of the writing or the facility another physician. I medication or dietary administered in according	ter medication or a dieta given to a resident only has approved the medication or supplem is ordered to do so by The over-the-counter y supplement must be ordance with the written nysician. The administra	if the ent in				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				A. BUILDING B. WING			
		NVS2808AGZ				03/1	4/2011
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
SPECIAL	LOVING CARE ALZHEIM	IERS CENTER		SA VISTA AV S, NV 89118	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
Y 877	Continued From page 7			Y 877			
		nedication and dietary included in the record paragraph (b) of subsec	ction				
	This Regulation is not met as evidenced by: Based on record review and interview on 3/14/11, the facility did not obtain physician orders to administer over-the-counter (OTC) medications to 2 of 4 residents, nor did they include the over-the-counter medications/dietary supplements on the medication administration record (Resident #3-Tylenol and Resident #4-Advil.) Severity: 2 Scope: 2						
Y 895 SS=F	449.2744(1)(b)(1) Me			Y 895			
	provides assistance to administration of medication of the medication and to administered; (3) The date and to administered; (3) The date and to or otherwise misses, medication; and (4) Instructions for medication to the resident.	lication shall maintain: edication administered fedication administered fecord must include: edication administered; ime that the medication ime that a resident refurant administration of	to was ses,				

		(X1) PROVIDER/SUPPLIER/G			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		N1/52909 A G7		A. BUILDING B. WING		02/4	; 4/2011
NAME OF DE	NVS2808AGZ OVIDER OR SUPPLIER STREET		STREET ADD	 RESS, CITY, STA	ATE ZIP CODE	03/1/	4/2011
NAME OF FR	OVIDER OR SUFFLIER			SA VISTA AV			
SPECIAL	LOVING CARE ALZHEIM	IERS CENTER		S, NV 89118	-		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODERICIENCY)	JLD BE	(X5) COMPLETE DATE
Y 895	Based on record reviet facility failed to ensure administration record of 4 residents (Mornir marked as given for FAlso, medications had for 11 days for Resident #1- prescrib (mg), but MAR read to Resident #2- prescrib MAR read to give 30	ot met as evidenced by: ew on 3/14/11 at 2 PM, e the medication (MAR) was accurate for ng medications had not Resident #1, #2, #3 and d not been marked as g ent #2). eed Seroquel 50 milligra o give 25 mg. ned Temazepam 15 mg mg ed Levetiracetam 1000	the or 4 been I #4. given ams	Y 895			
	Thyroxine, Aspirin and Lisinopril had not been marked as given from March 1st through March 11, 2011.						
	Severity: 2 Scope	: 3					
Y 930 SS=C	449.2749(1)(a) Resid Information	ent File-Storage, Res		Y 930			
	resident of a resident	st be maintained for ead ial facility and retained permanently leaves the	for at				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NIVO0000 A G 7		A. BUILDING B. WING	<u> </u>		C
NAME OF D	ROVIDER OR SUPPLIER	NVS2808AGZ	STREET AND	 RESS, CITY, STA	ATE ZIP CODE	03/1	14/2011
NAME OF PR	ROVIDER OR SUPPLIER			SA VISTA AV			
SPECIAL	LOVING CARE ALZHEII	MERS CENTER		S, NV 89118	_		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
Y 930	Continued From page 9			Y 930			
	that is resistant to fir unauthorized use. T records, letters, asse information and any the resident, including	other information related ng without limitation: Idress, date of birth and	st				
	Based on observatio to ensure resident fi place protected from	ot met as evidenced by in on 2/8/11, the facility les were kept in a locke unauthorized use (Res in an unlocked kitchen	failed d				
Y 936 SS=E	449.2749(1)(e) Resid	dent file-NRS 441A		Y 936			
	resident of a residen least 5 years after he facility. The file mus that is resistant to fire unauthorized use. T records, letters, asse information and any the resident, includin (e) Evidence of com	other information related og without limitation: pliance with the provisio S and the regulations	for at e ce cst				
	This Regulation is n	ot met as evidenced by	:				

AND DUAN OF CODDECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SI COMPLE	
				A. BUILDING B. WING			С
		NVS2808AGZ				03/	14/2011
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SPECIAL	LOVING CARE ALZHEIM	IERS CENTER		SA VISTA AV S, NV 89118	E		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
Y 936	Continued From page	e 10		Y 936			
	failed to ensure 1 of 4 NAC 441A.380 regard (Resident #1- no door step and no second s This was a repeat def	ew on 3/14/11, the facil residents complied with ding tuberculosis testing umented read date for the tep TB test completed) ficiency from the 2/16/1	th g first				
	annual State Licensu	·					
	Severity: 2 Scope	verity: 2 Scope: 2					
Y 991 SS=F	449.2756(1)(b) Alzheimer's Fac door alarm			Y 991			
	provides care to pers disease shall ensure (b) Operational alarm audible devices which	that: as, buzzers, horns or oth are activated when a ad on all doors that may	ner door				
	Based on observation 3/14/11, the facility fa doors had installed all the door was opened the garage and back. This is a repeat defici annual State Licensu grading re-survey.	illed to ensure 2 of 4 ex larms that operated who (Alarms did not sound door were opened). iency from the 2/16/10 re survey and 4/21/10	it en				
	Severity: 2 Scope	: 3					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM			(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		NVS2808AGZ		B. WING		03/1	; 4/2011	
NAME OF PR	OVIDER OR SUPPLIER	NVOZOGAGE	STREET ADD	I RESS, CITY, STA	ATE, ZIP CODE	03/1	7/2011	
SPECIAL	LOVING CARE ALZHEIM	ERS CENTER		SA VISTA AV S, NV 89118	E			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
Y 994	Continued From page 11			Y 994				
Y 994 SS=F	449.2756(1)(e) Alzhei items	imer's facility - Dangero	ous	Y 994				
	provides care to person disease shall ensure to (e) Knives, matches, to items that could consti	that: firearms, tools and othe	er					
	Based on observation to ensure dangerous	nen drawers).	failed ble to					
Y 999 SS=F	449.2754(1)(g) Alzhei substances	imer's Facility-Toxic		Y 999				
	provides care to perso disease shall ensure	that: es are not accessible to						

NVS2808AGZ NAME OF PROVIDER OR SUPPLIER SPECIAL LOVING CARE ALZHEIMERS CENTER A. BUILDING B. WING C 03/14/20 STREET ADDRESS, CITY, STATE, ZIP CODE 6562 W MESA VISTA AVE LAS VECAS NV 99449)11
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6562 W MESA VISTA AVE	
CDECIAL LOVING CADE ALZUEIMEDS CENTED	
LAS VEGAS, NV 89118	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 999 Continued From page 12 Y 999	
This Regulation is not met as evidenced by: Based on observation on 3/14/11, the facility failed to ensure toxic substances were inaccessible to 4 of 4 residents (Bleach and other cleaning supplies were found in an unlocked cabinet in the laundry room. The door to the laundry room was open and accessible to all residents.) Severity: 2 Scope: 3	